Appendix L
Public Comments and Responses

Public Comments on the 2001-2002 Texas State Health Plan Update during the period August 25 through September 15, 2000.

Summary by Goal and Objective:

Goal 1: Ensure that the needed number of health care professionals are educated and trained.

Objective 1.1: Conduct workforce supply and requirements planning for Texas 2000 – 2030

Jackie Johnson, Deputy Commissioner for Long Term Care at TDHS

Strategy 1.1.1, Action 2. TDHS recommends that the proposed "data collection system for health professionals" be rendered as a central (common) data repository for the health professions to better meet the needs of the state, professionals themselves, and the needs of public reporting. Such a common system should aim to address practitioner credentialing as well as the legitimate business needs of licensing and regulatory bodies.

ACTION: No action taken.

Strategy 1.1.3c, Action 2. TDHS recommends the addition of a fifth step in this action

e) To create incentives to expand the curriculum of Geriatric nurse specialists and encourage the recruitment and retention of geriatric nurse specialists.

Our concern here is primarily that Texas have a stable, well-trained cadre of nursing professionals to meet the needs of long term geriatric care.

ACTION: No action taken.

Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners

The Board of Nurse Examiners (BNE) has reviewed the Texas State Health Plan Update. The following concerns are issues for the BNE:

Comments on strategy 1.1.1 regarding the implementation of the Minimum Data Set (MDS):

Lock Box Requirements: The BNE uses the Comptroller's Lock Box to process license renewals. This system allows our agency to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, the BNE would be forced to either contract with a vendor to process the payments or hire additional staff to handle the work now done by the Comptroller.

ACTION: No action; the SHCC intends for the lock box procedure to continue as is. Since many of the data elements can be collected on the original licensing form, the lock box form need only collect those data elements that are likely to change, such as practice settings and address.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that SHCC was requesting that funds for the MDS be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory

subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

ACTION: Table 1-1 (Goal 1, Objective 1.1, Action 3) was amended to read, "The legislature should appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center which are required to implement and maintain the collection of that data."

The BNE is concerned with the ultimate source of the funding. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the appropriations for the MDS will be subject to a contingent revenue rider requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health professionals, including RNs. Any funding provided should be general revenue appropriated directly to the agency in charge of implementation and could include funds already collected by the Board in excess of current appropriations.

ACTION: See above change.

Biennial license renewals: The Ad Hoc Committee on Health Personnel Data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and the health professions licensing boards, which would include annual acquisition of data. The BNE has a biennial license renewal as a cost savings measure. Annual acquisition of the minimum data set would necessitate either a return to annual license renewals or implementation of a system solely to update data at the end of the first renewal year. Returning to annual renewal of licenses would result in an increase in workload by doubling the number of renewals processed each year. In addition, during the implementation period of reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect those agency's revenue projections for that period. Furthermore, the transition itself would be costly and would create confusion for licensees. The BNE does not believe that the cost and resource burdens of annual renewal are justified when weighed against the benefits of change. Attempts to collect data outside of the licensing process will also create costs for additional mailing and processing and may require extensive follow up.

ACTION: Table 1-1 (Goal 1, Objective 1, Action 3) was amended to read, "The Licensing Boards for those professions named should change their licensing and renewal forms and data systems to include the collection of the minimum data set on an annual or biennial basis."

Sensitive Data: Increasingly, licensees are reluctant to provide sensitive information such as ethnicity and place of birth. Although the use of social security numbers is protected by law, RNs are becoming increasingly resistant to the divulgence of their social security numbers. Their objections may lead to poor reporting or to potential liability on the part of state agencies.

ACTION: Since the reporting of this data is non-mandatory, the choice to provide sensitive information remains with the licensees. However, information obtained from health professionals must be protected by all parties under the same restrictions imposed upon the licensing agencies.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

ACTION: Table 1-1 (Goal 1, Objective 1.1, Strategy 1.1.1) was amended to state, "The reporting of health personnel data is non-mandatory for health professionals except for those data elements required for board administrative and regulatory purposes."

Katherine A. Thomas, MN, RN, Chair, Health Professions Council

Comments on strategy 1.1.1 regarding the implementation of the Minimum Data Set (MDS):

Lock Box Requirements: Four of the independent boards and 12 of the TDH boards use the Comptroller's Lock Box to process license renewals. This system allows the agencies to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, agencies would be forced to either contract with a vendor to process the payments or hire additional staff to handle the work now done by the Comptroller.

ACTION: See comments about Lock Box Requirements by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that funding for the MDS was to be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

ACTION: See comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

The Health Professions Council is concerned with the ultimate source of the funding. Member agencies are currently working on cost projections. Based on previous cost projections, it is expected that the cost to some agencies will be very high. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the appropriations for the MDS will be subject to a "contingent revenue rider" requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health care professionals. Further, since the projected cost to collect the data is greater in some agencies than in others, recovering the costs by charging the licensees in some cases is simply not practical. Any funding provided should be general revenue appropriated directly to the agency in charge of implementation.

ACTION: See comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Biennial license renewals: The Ad Hoc Committee on Health Personnel Data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and the health professions licensing boards which would include annual acquisition of data. Some member agencies have changed to a biennial license renewal as a cost savings measure. Annual acquisition of the minimum data set would necessitate either a return to annual license renewals or implementation of a system solely to update data at the end of the first renewal year. Returning to annual renewal of licenses would result in an increase in workload by doubling the number of renewals processed each year. In addition, during the implementation period of reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect those agencies' revenue projections for that period. Furthermore, the transition itself would be costly and would create confusion for licensees. Attempts to collect data outside of the licensing process will also create costs for additional staff, mailing and processing, and may require extensive follow up.

ACTION: See comments about biennial license renewals by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Sensitive Data: Agencies are reluctant to collect sensitive information they do not need, such as ethnicity and place of birth, due to potential liability.

ACTION: See comments about sensitive data by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

ACTION: See comments about enforcement by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Mary M. Strange, RN, BSN, Executive Director, Board of Vocational Nurse Examiners

Strategy 1.1.1, development of a Minimum Data Set. I believe the report accurately captures our concerns about changing our licensing and renewal forms and systems to collect the Minimum Data Set (MDS) information as insufficient agency resources.

Lack of necessary resources includes the fiscal impact related to the extensive revisions needed for start up, as well as the ongoing maintenance costs. Although the Draft Update indicates that BVNE collects all but 5 elements, in fact, those "elements" translate into 15 "field" changes of our database, as managed and supported by Northrop Grumman. Initial programming costs and monthly CPU time will be incurred. In addition, BVNE has inadequate personnel resources to do the extra work created by the MDS collection of information (pp. 25, 115).

ACTION: None required. This problem with implementing the MDS was addressed in the State Health Plan. See the NOTES for Table A-3. Many of the variables that were used with each data element or field in earlier versions of the MDS have now been designated as "board specific" and will be defined as each board determines. This difference between earlier versions of the MDS and the latest version (in which no variables were provided) accounts for most of the discrepancies between the boards and the SHCC.

It is not clear to me from the report who will be responsible for managing the data. On page 105, the report refers to the "data processing needed to be done by the boards" while p. 107 proposes that the "Texas Legislature appropriate funds to the HPRC to contract with the licensing boards to collect the extant data." The exact meaning of these comments should, perhaps, be clarified.

ACTION: As mentioned in the plan, the boards will manage the data, the HPRC will contract with the boards to collect the data and the data will be shared with the HPRC through a memorandum of understanding.

The report recommends a Memorandum of Understanding between HPRC and the licensing boards that would include annual acquisition of data. With 74,000 Licensed Vocational Nurses in Texas, this would be a monumental task! Currently, LVNs renew their licenses every two years, in odd or even years, depending on their year of birth. Therefore, we renew 'only' 36,000 licenses per year. The recommendation should allow either annual acquisition of data, or by renewal cycle, for those Boards that do not renew licenses annually (p. 109).

ACTION: None required. This problem with biennial license registration and implementing the MDS was addressed in the State Health Plan.

Interestingly, the MOU Scenario was not presented as an option in Table A-3 (p. 112), unless Scenario 1, the Board Scenario was implied to include the MOU. To more fully represent the options available, I recommend that a fourth option be included, that of HPRC and the Board working jointly through a Memorandum of Understanding.

ACTION: No action taken. An MOU would be required for the sharing of data under each scenario.

The last item concerning this strategy relates to funding. The report references funding by the licensees on at least two separate occasions: on pages 106 and 113. BVNE is strongly opposed to raising license fees to pay for data collection. The small sub-set of health care providers should not have to carry the burden of paying for data that will potentially benefit all Texans. A compromise, perhaps, since all Boards generate more revenue than they are appropriated, is for the Boards to use funds already generated for MDS collection. While this is not the preferred method of funding, the licensees would, in effect, support the project, but an increase in fees would not be required to do so.

ACTION: None required. This problem with funding and implementing the MDS was addressed in the State Health Plan.

Gary K. Cain, Ed D, Executive Director, Texas State Board of Chiropractic Examiners

I have the following concerns about your plan:

1) Our agency does not collect sensitive data because it is not needed to protect the public and regulate our licensees. Race/ethnicity, place of birth, high school location and licensee Social Security number should not be collected or disseminated.

ACTION: See above comments about sensitive data by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

2) Several members of the Health Profession Council use the Lock Box System, and they should not be required to change that procedure.

ACTION: See above comments about the Lock Box System by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

3) The TBCE has just completed a redesign to all agency databases, and to make substantial changes again to collect additional data that is unnecessary to accomplish our mission is counterproductive. There is also the likelihood that this extraneous data will soon have additions or revisions

ACTION: Boards will be funded to implement the MDS to bring them into compliance with the MDS workforce data collection system.

4) Rather than altering numerous regulatory databases, SCHH needs to seriously consider developing its own on-line database that can be accessed directly by all of the targeted licensees. SCHH would not have to compromise its desired Minimum Data Sets, and regulatory agencies already swamped with their own work would not have to interrupt their primary missions to do this extra work for SCHH.

ACTION: The results of workforce surveys conducted in other states and Texas indicate that poor response rates are typical when licensees are asked to respond to surveys that are not mandatory, as will be the MDS. Thus, the usefulness of collecting data by an on-line survey system is questionable. The results from the pilot system that is currently being tested by the HPRC will help to answer this question later this year.

5) The Legislature would need to pass legislation requiring all targeted health care licensees to complete the requested information on-line. After the initial on-line survey is completed, the survey could easily be

updated annually. In the long run, this method would be more efficient and the data could be processed and disseminated with greater ease. Over the years, this method would also cost less and result in more efficiency than any of the other proposed scenarios.

ACTION: See the response to item (4) above.

All members of the Health Profession Council feel the Minimum Data Set information has the potentiality to provide desirable information to the Texas Statewide Health Coordinating Council and ultimately the information would be useful.

SHCC must understand that the regulatory agencies are currently understaffed and overworked. Even if additional funding were approved for additional FTE's, our offices are so crowded that we have no room to expand for additional workstations, new staff members and additional furniture or equipment.

Gay Dodson, R Ph, Executive Director, Texas State Board of Pharmacy

Implementation: As stated in previous correspondence to the Statewide Health Coordinating Council, the collection and maintenance of the Minimum Data Set (MDS) by the Texas State Board of Pharmacy is not possible without additional funding, including additional FTE's. All data fields identified are either not collected, are collected only at initial licensure, or are collected on a biennial basis only. The Fiscal Impact Assessment Instrument is enclosed.

ACTION: See above comments by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Funding: If funding for the MDS is appropriated directly to the agency, we are concerned that the appropriations for the MDS will be subject to a "contingent review rider" which would require the agency to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. Any additional appropriations under this rider would require the Board to increase fees to the individual licensees of the Board, thus the cost to implement the MDS would be borne by the licensed pharmacists.

ACTION: See above comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Biennial License Renewals: The TSBP has implemented a biennial license renewal system. Annual acquisition of the MDS would necessitate either a return to annual license renewals or implementation of a system solely to update data on an annual basis. Returning to the annual renewal of licenses would result in an increase in workload by doubling the number of renewals processed each year. The process to convert from a 1-year to a 2-year phased in renewal system took 123 hours of programming time. This programming work would have to be reversed to accommodate a 1-year renewal period and it is anticipated this process would require 130 hours of programming time. In addition, during the implementation period reverting from a biennial to an annual license renewal, a significant decrease in revenue will occur which will negatively affect the TSBP revenue projections for that period.

ACTION: See above comments about biennial license renewals by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Lock Box Requirements: The TSBP uses the Comptroller's Lock Box to process all license renewals. This system allows the agency to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. This system is primarily dependent upon a streamlined, concise renewal application form. Comptroller requirements will not allow any increase in the size of the renewal application and will not allow for attachments. If Lock Box were eliminated, the agency would be required to begin processing all cash at the agency site, which would require a minimum of 1 additional FTE. In addition, the security of cash receipts must be addressed. Bringing the cash receipts back into the agency would not only present an increased security risk, but would also delay the deposit of these monies into the State Treasury by at least 1 day.

ACTION: See above comments about lock box requirements by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. The Coordinating council should clarify this issue within Table 1-1.

ACTION: See above comments about enforcement by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Sherry L. Lee, Executive Director, Texas State Board of Examiners of Psychologists

Please note that in addition to this letter, the Board (Texas State Board of Examiners of Psychologists) has other concerns about the recommendations in the plan, which are addressed by the joint letter sent under separate cover from the Health Professions Council of which this Board is a member.

The Board is concerned that psychologists continue to be included in the First Priority list of professionals to collect the MDS, despite the fact that it was previously indicated to this Board that this professional was not in the priority list presented by the institutions of higher education of this state for information to be used for workforce analysis.

ACTION: Psychologists will continue to be included in the First Priority List for implementing the MDS.

Also, contrary to the information in the drafted plan, the information to be collected for the MDS for this Board would require a total of 22-26 new fields of data to be collected and entered on the database per licensee. Hence, the high cost estimates for implementing the recommendations for this agency which will be submitted to you by your stated deadline for receiving these cost estimated of September 22, 2000.

ACTION: None required. Many of the variables that were used with each data element or field in earlier versions of the MDS have now been designated as "board specific" and will be defined as each board determines. This difference between earlier versions of the MDS and the latest version (in which no variables were provided) accounts for most of the discrepancies between the boards and the SHCC.

Most importantly, this Board would recommend, as an alternative to the recommendations presented in the drafted plan, that this Minimum Data Set be a non-mandatory effort implemented like the current pilot project that was suggested by the Regulatory Subcommittee of the House Appropriations Committee. This pilot project allows selected professions to voluntarily provide this MDS information through the Department of Health website. The agencies participate by sending notices to the licensees with their renewals stating that this information needs to be submitted for the purpose of workforce analysis via this website. It is this Board's understanding that such a project if implemented for all regulatory agencies would have only a minimal cost impact on these regulatory agencies and therefore would be by far the most economic and user friendly method of collected this data. Also, such a voluntary project would protect the privacy rights of those licensees who take issue at some of the data that would be collected. Individual information submitted to a state agency, such as the MDS, would be subject to open records even though the purpose of collecting this information is primarily for workforce analysis such as distribution, projections, etc.

ACTION: See response to comments by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Skip Langley, Texas State Board of Medical Examiners

Strategy 1.1.1, Minimum Data Set: Collection of this data is not an issue for the Board of Medical Examiners as we currently collect most items in the data set. However, we would like to share with you the concerns recently expressed to us by our licensees about the collection and dissemination of data via electronic databases. As information once held in paper files is transferred to electronic formats, new concerns arise about its use. We, like other state agencies, have encountered increased tensions between the "right to know" and the right to privacy. We have received formal resolutions from two local medical societies about the collection or dissemination of information about ethnic origin, place of birth and date of birth. I encourage the Coordinating Council to proceed with caution in creating this new database. Also, any efforts to amend HB 692 and loosen the current protection of Social Security Numbers must be carefully considered and tightly written.

ACTION: See response to comments about sensitive data by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Lois Ewald, Executive Director, Texas Optometry Board

In regard to Strategy 1.1.1, the implementation of the Minimum Data Set (MDS), funding continues to be our primary concern. It was our understanding that appropriations from General Revenue would be requested for the Statewide Health Coordinating Committee (SHCC) to be used to contract with the state health licensing boards for the required minimum data set. The Plan Update recommends that the House Regulatory Sub-committee appropriate funds to the agencies for such implementation.

ACTION: See response to comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Should such appropriations be granted by the Legislature to agencies, most probably the agencies will be required to assess fees to generate sufficient revenue to cover such funding request. These increased fees would have to be passed on to the individual licensees of the board. Agency budgets are not sufficient to absorb these projected costs but to further tax licensees for such data gathering is not a viable action and alternatives to funding should be sought.

ACTION: See response to comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Although this Board collects much of the data requested, to change renewal form applications and programs to gather additional data would be an increased cost, not to mention costs for additional mailings, as well as additional staff for collection, recording, and follow-up in regard to the MDS. The FTE cap would be a limitation currently. Additionally, much of the requested data may be sensitive, and we question the need for such information.

ACTION: See above comments about sensitive data by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Enforcement is a concern, also. If licensees must provide all of the required data as a condition of licensure, it will be costly to implement for the reasons cited above as well as the need for enforcement hearings. While the report states that provision of the MDS data will not be mandatory, we request that SHCC clarify the issue within Table 1-1.

ACTION: See response to comments about enforcement by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Becky Berryhill, MPA, Chief, Bureau of Licensing and Compliance, TDH

Lock Box Requirements: The programs use the Comptroller's Lock Box to process license renewals. This system allows the agencies to meet the state's three-day deposit requirement and generates additional state revenue by assuring immediate deposit of funds. Comptroller's requirements will not allow any increase in the size of payment coupons and will not allow for any attachments. Therefore, the Bureau would be forced to contract with a vendor to process the payments. Payments made through the TDH take three weeks on average to process.

ACTION: See response to comments about Lock Box Requirements by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Funding: Implementation is not possible without additional funding. The Ad Hoc Committee on Health Personnel Data recommended appropriation of funds to the Statewide Health Coordinating Committee to be used to contract with the state health licensing boards for them to collect the MDS. The Plan Update recommends that the House Regulatory sub-committee appropriate funds to cover the costs of implementing the minimum data set and raise the FTE cap for those licensing boards and the Health Professions Resource Center.

It was our understanding that funding for the MDS was to be appropriated from general revenue funds directly to the Texas Department of Health. The House Appropriations Regulatory subcommittee serves only Article VIII agencies and should not be referenced as the subcommittee to appropriate the funds. The reference should be to the Legislature.

We are concerned with the ultimate source of the funding. Member agencies are currently working on cost projections. Based on previous cost projections, it is expected that the cost will be very high. If funding for the MDS is appropriated directly to the licensing agencies, there is concern that the appropriations for the MDS will be subject to a "contingent revenue rider" requiring agencies to assess fees to generate sufficient new revenue in excess of the Comptroller's Revenue Estimate. The effect of this rider is that any additional appropriations to a licensing board results in increased fees to the individual licensees of that board. If MDS funding were subject to this condition, full cost of implementing the MDS would be borne by the licensed health professionals. Any funding provided should be general revenue appropriated directly to the department.

ACTION: See response to comments about funding by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Software: At least two of the licensing systems currently used are so antiquated that additional data field cannot be added to record the requested information.

ACTION: Cost of implementation would include infrastructure funding.

Biennial license renewals: The ad hoc committee on health personnel data recommended the development of a Memorandum of Understanding between the Health Professions Resource Center and programs, which would include annual acquisition of data. Some programs have a biennial license renewal. Annual acquisition of the minimum data set would necessitate implementation of a system solely to update data at the end of the first renewal year. Attempts to collect data outside of the licensing process will create costs for additional mailing and processing and may require extensive follow up.

ACTION: See response to comments about biennial license renewals by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Sensitive Data: Programs are reluctant to collect sensitive information they do not need, such as ethnicity and place of birth, due to potential liability.

ACTION: See response to comments about sensitive data by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Enforcement: It will be much more difficult and costly to implement the MDS if licensees must provide all of the required data as a condition of licensure. While the strategy and actions do not address this issue, the body of the report states that provision of the MDS data will not be mandatory for licensees. We request that the Coordinating Council clarify this issue within Table 1-1.

ACTION: See response to comments about enforcement by Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners.

Geocoding: The Department included expansion of geocoding activities in the Comprehensive Strategic & Operation Plan for FY 2001- 2002. National standards for database configuration should be adopted for the key address elements.

ACTION: No action required. A file layout for the MDS was developed by the SHCC Health Personnel Data Subcommittee but a recommended list of variables for each data field was not identified in the State Health Plan. This allows the boards' flexibility in designing the MDS to suit their particular board when funding becomes available. Flexibility is important because some data fields and variables are not appropriate to some boards. Substituting the "zip code" field for a "zip code plus four" field would accommodate some geocoding requirements.

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

- Strategy 1.1.2: We are in support of conducting work force project studies and surveys that will encourage work force and education policy development. However, we are concerned that the Integrated Requirements Model is not adequate to project supply and demand data for professional nurses. Although this model does appear to be accurate in projecting requirements for physicians and mid-level providers, we would not recommend relying on it for projections regarding professional nurses. This leads us to believe that a parallel entity would be necessary to accurately project complementary nursing workforce data.

ACTION: The State Health Plan indicates that the Integrated Requirements Model should not be the sole determinant for estimating the requirements for health professionals in Texas. See Chapter 2, Introduction, Workforce Models Used in this Report.

- Strategy 1.1.3: We are in support of the concept of reexamination of formula funding, particularly as it relates to the biennial funding lag that hampers nursing's ability to respond rapidly to changing market demands.

ACTION: No change required.

- Strategy 1.1.3a (3): We believe it is crucial that the state increase financial support of nursing programs to help allay the current and ever worsening nursing shortage.

ACTION: No change required.

- Strategy 1.1.3a(4): Although we support the establishment of automated data collection systems, because of the severity of the nursing shortage, we believe that collection of information about nursing should have the highest priority. Through our collaborative efforts among the nursing groups we know that nurses are willing to support a Nursing Data Collection Center funded through increases in licensing fees.

ACTION: No change. The SHCC fully supports the nursing profession's priorities for study of how to alleviate the statewide shortages of nurses; however, the SHCC does not concur with the position that a separate center be established for one profession. The SHCC believes that the cost of profession-

specific centers would be too high and that a consolidated, comprehensive approach to shortages and/or maldistribution is preferable.

- Strategy 1.1.3c: We enthusiastically support this recommendation and believe it provides the best strategies for addressing the nursing workforce needs.

ACTION: No change required.

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Health Personnel Data – Strongly support all five recommendations

ACTION: No change required.

Goal 2: Improve health professions regulation to ensure quality health care for Texas

Objective: 2.1 Establish fair and equitable mechanisms and processes that will address health profession regulation

Louis J. Goodman, PhD, CAE, Executive Vice President/CEO, Texas Medical Association

> We appreciate the opportunity to review the draft recommendations contained in the "2001-2004 Texas State Health Plan Update" and offer only brief comments regarding Strategy 2.1.1 Scope of practice issues are often highly charged, emotional issues that potentially can affect access, cost, and quality of case. Accordingly, TMA is willing to explore a process for evaluation scope of practice recommendations. Our association feels it is appropriate to propose a legislative study during the 2001/2001 interim period to focus on processes for addressing scope of practice issues.

ACTION: No change required.

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

> Strategy 2.1.1 we are in support the creation of a fair and equitable process for addressing changes in scope of practice for health professionals.

ACTION: No change required.

Lynda Woolbert, MSN, RN, CPNP; Director of Public Policy; Coalition for Nurses in Advanced Practice

> Pages 16 through 18 continue to discuss scope of practice issues and suggest a sunrise process before the Legislature considers such legislation. Since CNAP has participated in a negotiation process with Texas Medical Association to develop scope of practice legislation since 1995, we certainly appreciate the importance of developing a fair process to resolve these issues. While CNAP supports such a process, we are concerned that sunrise and arbitration processes might be enacted without adequate funding for staff. If this were the case, such a data-driven process would rely largely on the information brought by associations. Because of the difference in resources that physician associations have versus other health care professional associations, the process could be inherently unfair. We understand that such issues would be brought to light during the interim study suggested in Strategy 2.1.1, and that the Council partially addressed this issue in Action # (1)(b). However, CNAP suggests that the report address this issue specifically by adding an additional action, (1)(c), to read as follows: "Consider variations in financial and staffing capacities among professional organizations in developing a fair and equitable process."

ACTION: No action.

Goal 3: Address the maldistribution of health professionals.
Objective: 3.1: Increase access to health care through technology

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

Strategy 3.1.1 (1): We are in support of plans to address the maldistribution of health care professionals while increasing access to rural and underserved population through funded programs that expand the use of telehealth/distance technology. However, we believe that it is critical that professional nurses be included in telehealth reimbursement opportunities. This is especially important to increase access to health care in rural and underserved populations.

ACTION: No change required. This is essentially a "scope of practice" issue. However, the SHCC adopted the following language to this section:

1) The State Legislature should include telemedicine third-party reimbursements for Medicaid, Children's Health Insurance Program, Texas Healthy Kids Corporation and other state-sponsored programs in the state's mandated coverage.
   The following practitioners should be considered for third party reimbursement for telemedicine / telehealth services: physicians, dentists, clinical psychologists, advance practice nurses, physician assistants, certified nurse midwives, clinical social workers, occupational therapists, physical therapists, speech therapists, marriage and family therapists, and other licensed health care providers. The state should consider issues related to scope of practice, fraud and abuse, and quality of care.

Lynda Woolbert, MSN, RN, CPNP; Director of Public Policy; Coalition for Nurses in Advanced Practice

CNAP also supports Strategy 3.1.1. Telemedicine is an important strategy to address maldistribution of health care providers. Obviously, we appreciate that the SHCC recommends reimbursement for telehealth services provided by APNs. However, CNAP also strongly recommends that the report specifically identify registered nurses as providers who should be reimbursed for presenting patients. RNs are educated in physical assessment and may be the most appropriate presenters in some remote areas of Texas or in some school-based clinics. Action # 1 certainly includes the possibility of reimbursing RNs for this service by including "other health care providers" in the listing of health care professionals that the state should consider for reimbursement. However, CNAP asks that the SHCC specifically include RNs in that list.

ACTION: Strategy 3.1.1, Action 1) includes the following language, "The following practitioners should be considered for third party reimbursement for telemedicine/ telehealth services: physicians, dentists, clinical psychologists, advance practice nurses, physician assistants, certified nurse midwives, clinical social workers, occupational therapists, physical therapists, speech therapists, marriage and family therapists, and other licensed health care providers."

Objective 3.2: Increase access to health care through the coordination of recruitment and retention activities

Connie Berry, Program Administrator, Community Health Provider Resources, TDH

Our office, Community Health Provider Resources (CHPR) in the Bureau of Community Oriented Public Health, is the state Primary Care Office. Our cooperative agreement with the Health Resources and Services Administration of the federal government identifies four key activities:

- Improve access to primary care providers of medical, dental and mental health services
- Recruitment and retention of primary care providers in these disciplines

- Leverage resources to improve access, and
- Build organizational capacity of communities to serve the underserved

Our partner in these activities is the Center for Rural Health Initiatives. We have a strong, positive relationship with the Center. While their focus is improving rural access and workforce development, our focus is broad— to improve access for all underserved areas in Texas.

Our recommendations would be to identify CHPR, along with the Center for Rural Health Initiatives (CRHI), as a key resource to carrying out the following strategies and actions in the State Health Plan. The strategies include: 1.1.2 Workforce studies and surveys, 3.2.1 Expanding state loan repayment programs and accessing federal matching dollars, and 3.2.2 Convening a collaborative partnership to coordinate statewide recruitment and retention of health professionals. In reference to Strategy 3.2.1, action 2) contracting out the administration of the new loan repayment programs should be a decision reached through discussions with the Texas Higher Education Coordinating Board, the CRHI and our office. These programs will use Health Professional Shortage Area designations for eligibility and those areas are statewide, not just in rural communities.

ACTION: Added Community Health Provider Resources (TDH) as a responsible party in 1.1.2.

ACTION: The council changed the language to Strategy 3.2.1. Action 2) to make it less restrictive, recommending only that The Higher Education Coordinating Board contract out administration of the financial incentive programs.

ACTION: The SHCC named itself as the convener of a partnership of agencies under Strategy 3.2.2.

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Recruitment of Health Professionals – Support all primary and secondary recommendations – especially recommendation three which proposes a State-specific method for determining Health Professional Shortage Areas. Once again, dentistry could be given some specific mention in these recommendations.

ACTION: No change required.

Lynda Woolbert, MSN, RN, CPNP; Director of Public Policy; Coalition for Nurses in Advanced Practice

Action # 7 in Strategy 3.2.2 recommends development of a plan for a physician relief service for rural physicians. CNAP strongly recommends that APNs and physician assistants (PAs) also are included in a plan for relief services. Some APNs and PAs are already providing essential services in remote areas, just as physicians do. For example, according to a 1998 study using 1997 Texas data, certified registered nurse anesthetists (CRNAs) work in 78 counties in which no anesthesiologist resides. If the SHCC's recommendations are implemented, there may be an increasing number of rural APNs and PAs who need occasional relief. Therefore CNAP recommends that Action # 7 read as follows: "Develop a plan for a relief service for rural physicians, advanced practice nurses, and physician assistants."

ACTION: The SHCC changed the language in Action 8) to read, "Develop a plan for a relief service for rural health professionals."

Goal 4: Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health

Objective 4.1 Increase the implementation of prevention activities in the health care community through the academic curriculum

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

Strategy 4.1.1: Nurses have long been proponents of emphasizing prevention in nursing education through our curricula and the use of community-based training sites.

ACTION: No change required.

Objective 4.2: Build the competencies of the public health workforce in the areas of core public health functions

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

Strategy 4.2.1: We believe nursing is critical to the public health workforce; therefore, collaborative efforts to enhance the education and training of the public health workforce must include nursing education endeavors.

ACTION: No change required.

Objective 4.4: Develop a coordinated approach to education of children in grades K-12 to encourage healthy lifestyle choices.

ACTION: No change.

Goal 5: Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce

Objective 5.1: Develop a diverse and culturally competent workforce

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

Strategy 5.1.1: We enthusiastically support the strategies for increasing the number of minorities in the health professions.

ACTION: No change required.

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Minority Health – Support all four recommendations.

ACTION: No change required.

Objective 5.2 Develop a workforce equipped to meet the needs of Texas's aging populations and the population of persons with disabilities

Christy Fair, Policy and Planning, Texas Department on Aging

"We are thrilled to see the Interagency Aging Policy Council's report on "A Healthy Aging Texas" and its recommendations contained within the report."

ACTION: No change required.

Jackie Johnson, Deputy Commissioner for Long Term Care at TDHS

Strategy 5.2.3 THDS recommends amending the phrase "feasibility of providing..." to "feasibility and health benefit of providing..."

ACTION: This change was made.

Strategy 5.2.3 Actions: TDHS recommends adding a third action that will operationalize the proposed change to the wording of the strategy.

3) Provide quality review and evaluation of the impact of the pilot on Total Cost of Healthcare as an integral part of the pilot's design.

ACTION: This change was made.

The issue in action (3) is to assure that the pilot is evaluated rigorously and that the design of that evaluation is deliberate and pre-implementation rather ad hoc and post-implementation. Our concern for rigorous evaluation stems from national level studies that demonstrate the enormous health and financial burden caused by adverse drug reactions that stem in part from inappropriate prescribing, the vulnerability of the proposed beneficiary population, and the risks inherent in modern polypharmacy.

Alexia Green, RN, PhD, Chair, Nursing Education Policy Coalition

Strategy 5.2.1: Since nurses currently provide a significant portion of the health care to the elderly, it would be remiss of the Council to exclude nursing as a responsible party in the study of the needs of the elderly. We recommend that the Texas Nurses Association and the Nursing Education Policy Coalition be identified as responsible parties for implementing this strategy.

ACTION: Texas Nurses Association is already included; the Nursing Education Policy Coalition was not added.

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Texas Department on Aging – Strongly support all ten recommendations – although not specifically, mentioned there is a role for dentistry here as well.

ACTION: No change required.

Goal 6: Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens

Objective: 6.1: Design systems in which local communities are empowered to plan and direct interventions that have the greatest positive impact on the health of citizens

William R. Archer III, MD, Commissioner of Health

Dr. Archer expressed the wish to see a more positive expression for "alternative medicine" and a recommendation to integrate health and wellness approaches that include the diverse members and attitudes of each community.

ACTION: The following action was added:

Action 1) (e) Assessment and better understanding of complementary and integrative approaches to health and wellness used by diverse cultures that have a positive impact on the community.

"We fully support your work and the new plan update."

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Models for Community Health Practice – These recommendations are rather general in character, but probably worth supporting.

ACTION: No change required.

Objective 6.2: Develop the skill level of health professionals in working with communities

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Community Competencies for Health Professionals – Support all six recommendations (this should be of particular interest to SRPH).

ACTION: No change required.

Goal 7: Develop the health care partnership between consumers and health care professionals through increased access to health care information

Objective 7.1: To enable consumers to make better health care decisions

Mary M. Strange, RN, BSN, Executive Director, Board of Vocational Nurse Examiners

Strategy 7.1.1, Consumer Health Care Information. I am unclear about what SHCC is proposing with this strategy. Certainly, BVNE would cooperate in coordinating with the Texas Health Care Information Council (HCIC) in providing information that helps educate health care consumers. However, the wording implies that the HCIC would also provide an oversight and quality control function as well (pp. 44 & 307). BVNE opposes designating HCIC to provide an oversight function of regulatory Boards.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Gay Dodson, R Ph, Executive Director, Texas State Board of Pharmacy

Goal 7, Objective 7.1, State Strategy 7.1.1

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and entities involved in consumer health information activities. It is our understanding that the Health Care Information Council was to coordinate activities among state agencies. It appears, however, that the Council has been designated as an oversight Council with a broader role and responsibilities. The language contained in the action steps is unclear – specifically, what is the intent of the Council?

The Texas State Board of Pharmacy supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan and we applaud the work that has gone into this Plan Update. We have only commented on the areas that are of concern to us. We believe that implementation of the Plan will serve Texas citizens to reach and maintain optimum health as well as to make health care services and facilities available to all Texans.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Katherine A. Thomas, MN, RN, Chair, Health Professions Council

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council:

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. The Health Professions Council had the understanding that the Health Care Information Council was to have a coordinating role as opposed to a role of oversight. The Health Professions Council is unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

The Health Professions Council supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan; and, we appreciate the work that has gone into this Plan Update. We have only commented on the areas that are of concern to us. We appreciate the opportunity to provide input to the Plan Update. Please call if there are any questions regarding our feedback.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Katherine A. Thomas, MN, RN, Executive Director, Board of Nurse Examiners

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council.

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. It was the BNE's understanding that the Health Care Information Council was to have a coordinating role as opposed to a role of oversight. The BNE is unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

The BNE supports the work and direction of the Statewide Health Coordinating Council's Texas State Health Plan; and, we appreciate the responsiveness of SHCC to our past concerns as reflected in this Plan Update. We have only commented on the areas that are of concern to us. We appreciate the opportunity to provide feedback to the Plan Update.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Skip Langley, Texas State Board of Medical Examiners

Strategy 7.1.1, Consumer Health Information: We enthusiastically support the development of a clearinghouse for consumer information. However, the plan seems to be unclear about the role that is being designated for the Texas Health Care Information Council. It was our understanding that the Ad Hoc Committee on Consumer Information had recommended that the Texas Health Care Information Council coordinate with agencies in providing consumer information. In Table 1-1, it appears that oversight authority is being created and vested in the Health Care Information Council with a responsibility for "evaluation and quality assurance functions." Conversations with Council staff confirmed the intent of the Ad Hoc Committee and we are submitting the following language to clarify this intent:

Modified Text for Chart:

1) The Texas Health Care Information Council should develop a state of Texas clearinghouse that provides one-stop access to health and insurance-related information.

2) The Texas Health Care Information Council should coordinate and organize the information available from state agencies and state entities involved in consumer health information activities. Responsibilities include:

a. Collecting and analyzing data relevant to consumer information and consumer choice;

b. Providing and disseminating data related to consumer choice of health plan, provider and treatment options; and

c. Recommending methods for organizing data relevant to consumer information and consumer choice.

Modified Text for Plan Details:

Recommendation One: The State of Texas should develop a clearinghouse that provides one-stop access to health and insurance-related information. There is a wealth of information about health available to consumers, not only from state agencies, but also from community-based organizations, advocacy groups and the private sector. This information should be maximized and coordinated to provide seamless access to information.

Information is only of value if it gets into the hands of the people who need it, in a form that it can be used. A number of agencies and organizations in Texas compile information that could help consumers make important health care and insurance decisions. But consumers are not likely to know which agencies to contact and may be frustrated by the difficulty and amount of time involved to access it. A clearinghouse, using a variety of outreach strategies (Internet, 1-800 line, etc.) can provide one-stop, access to health and insurance-related information is needed in the state of Texas.

This clearinghouse would include an Internet website providing links to agencies and organizations that compile and publish information beneficial to consumers making health care and insurance decisions. Consumers visiting the site would access general information published by one agency, register complaints to another agency and browse through quality of care information published by yet another agency. The site would be seamless to the user. The clearinghouse's development and maintenance would be the responsibility of the Texas Health Care Information Council.

Recommendation Two: The governor, in conjunction with other state leaders, should designate the Texas Health Care Information Council as the agency to coordinate and organize the information available from state agencies and state entities involved in consumer health information activities (i.e.: Texas Health Care Information Council, Office of Public Insurance Counsel, Texas Department of Insurance, Licensing Boards, and the Texas Department of Health). The Consumer Information Ad Hoc Committee strongly urges that the Texas Health Care Information council serve as the lead agency and receive funding appropriate to carry out this role.

Responsibilities should include:

(1) collecting and analyzing data relevant to consumer information and consumer choice;
(2) providing and disseminating data related to consumer choice of health plan, provider and treatment options; and
(3) recommending methods for organizing data relevant to consumer information and consumer choice.

ACTION: The language above was used in place of the original recommendation. The only difference is that in the first paragraph of Recommendation One, the text was changed from "The State of Texas should develop…" to "The Texas Health Care Information Council should develop…"

Lois Ewald, Executive Director, Texas Optometry Board

Concerning Strategy 7.1.1 regarding the Texas Health Care Information Council (HCIC), we have concerns that the council would be given the oversight to determine the roles and responsibilities of state agencies and state entities involved in consumer health. It was our understanding that the HCIC was to have a coordinating role as opposed to a role of oversight. We question what is meant by "evaluation and quality assurance functions" listed therein. Such language should be revised to clarify the role of the HCIC as one of coordination for consumer health information rather than oversight.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Becky Berryhill, MPA, Chief, Bureau of Licensing and Compliance, TDH

Comments on strategy 7.1.1 regarding the Texas Health Care Information Council.

The Texas Health Care Information Council is designated as the agency to clarify the roles and responsibilities of state agencies and state entities involved in consumer health information activities. We do not agree with the Council's proposed oversight role. We are unclear what is meant in the action number 1, c) evaluation and quality assurance functions. We suggest that the

language of strategy 7.1.1 be revised to clarify the role of the Health Care Information Council as one of coordination rather than oversight.

ACTION: Language of the recommendation was revised to clarify the role of the THCIC as one of collection and coordination rather than oversight.

Dr. James S. Cole, Dean of Dentistry, Texas A&M University Health Science Center

Ad Hoc Committee on Consumer Information – Both of these recommendations appear to be supportable.

ACTION: No change required.

Priscilla Boston, Texas Health Care Information Council

(You) might want to add significant progress towards release of Texas' first hospitalization data in PP that begins "In all".

ACTION: No change required. This comment is not germane the subject of the paragraph.

Not sure we agree with conclusion in first PP under Background that "As the health care environment has become more complex the development of the consumer-provider partnership has become critical." We think it may have more to do with advances in health care diagnostics, the plethora and availability of conflicting information, and perhaps most importantly because of advanced analytical sophistication of the consuming public--whether it be goods or services they're purchasing.

ACTION: Wording changed to read: The health care environment has become more complex. Advances in health care diagnostics added to the availability of often conflicting information, and because of the increasing analytical sophistication of health consumers a new paradigm needs to be developed in the relationship between health care consumers and providers. The need for development of the consumer-provider partnership has become critical.

(You) might want to modify a sentence in the last PP. "Care should be designed to facilitate consumer compliance with medical recommendations, convenience and satisfaction". The medical care system also needs to apply psychosocial research on patient resistance to being compliant in order to improve that factor. We need to understand why patients do not comply and address those hurdles somehow.

ACTION: No changes required. While this is an important factor in the provider-patient relationship, it is outside of the scope of the SHCC charge.

In Changes in the HC System – maybe the increase in collaboration is an outgrowth in broader trends of philanthropy (collaboration required by funders, more social justice funding....)

ACTION: No changes required. While this is an important factor in the provider-patient relationship it is outside of the scope of the SHCC charge.

In first PP you reference changes in hc info supplier roles to be to help INTERPRET info, but that isn't fully explored/defined in the recommendation for a clearinghouse. The clearinghouse recommendation seems like more of a planning task (clarify roles of existing agencies/stakeholders) rather than adding services that aid the public in interpreting info.

ACTION: Change in wording of recommendation addresses the issues in this comment.

In the indented PP that begins "Before the entire online..." we are unfamiliar with the language construct "will lease the industry forward".

ACTION: Mr. Mack is saying that coming to a consensus on ethical principles will guarantee that future efforts of the online health industry will maintain high standards. Mr. Mack approved changing the word "lease" to "move".

1st PP under States Providing..... HB 3021 needs better definition. Use of the concept "statewide clearinghouse for health care information" sounds more or less the same as what this group is recommending the creation of. Why recommend something that's already there? More careful review of that legislation may be in order, and you might want to clarify that it mandates TDI to do that and it's mostly to facilitate complaints/appeals for services....

ACTION: Change in wording of recommendation addresses the issues in this comment.

General Comments

Rumaldo Z. Juarez, Dean, College of Health Professions, Southwest Texas State University

The plan is deficient in addressing the allied health workforce and completely neglects the role of institutions like SWT in producing healthcare professionals throughout the state.

ACTION: No change. This should be an item of priority for the next SHP update.

Lois Ewald, Executive Director, Texas Optometry Board

The Health Professions Council is forwarding comments on behalf of member boards, and we concur with the comments made therein.

ACTION: No change required. Referred to other member boards.

Allison Ratliff, Midwife

In the section about Community Care, there is no mention made of midwives.

ACTION: No change taken. This plan update could not address the allied health professions in depth

University of North Texas Health Science Center at Fort Worth

Notes apparent errors in Chapter Two. Table 2-1 and Exhibit 2-1.

ACTION: Corrections were made to the table and exhibit as suggested.

Lynda Woolbert, MSN, RN, CPNP; Director of Public Policy; Coalition for Nurses in Advanced Practice

The Coalition for Nurses in Advanced Practice (CNAP) appreciates the hard work of the Statewide Health Coordinating Council and staff in developing the draft of the Texas State Health Plan biennial update for 2001-2002. As the primary organization representing advanced practice nurses in Texas, we certainly support the recommendations included in the draft report. We do wish to comment on a few points of particular importance to our profession.

On page 16, under "Scope of Practice" on lines 1 and 5, the report refers to scope of practice being defined in "medical practice acts." This is confusing since there is only one Medical Practice Act and it regulates physicians, physician assistants and acupuncturists. Other health care professions have their own practice acts. For instance, authority for advanced practice nurses (APNs) is found in the Nurse Practice Act. Therefore on lines 1 and 5, CNAP recommends changing, "the medical practice acts" to "professional practice acts."

ACTION: No change.

The substitution grid for physicians and non-physician providers on pages 94 and 95 contains some errors. On page 95, under psychiatrists, clinical nurse specialists are listed twice and the two listings have different substitution factors. Under the category of anesthesiology, physician assistants, who are not trained to deliver anesthesia in their educational programs, are listed twice with two different substitution ratios, but CRNAs, who deliver 65% of all the anesthetics in this country, are not listed at all. In addition, the grid

shows that PAs work in otolaryngology, urology and other specialty practices, but does not show the fact that nurse practitioners (NPs) also work in many of these specialties.

In addition, the draft report contains very little information on how the substitution model should be interpreted and its limitations. If the reader takes the information in the table at face value, erroneous conclusions may be drawn. For instance, all published estimates indicate that a family nurse practitioner can properly evaluate and treat from 60 to 90% of the patients seen by a family physician. Therefore, even if the model accounts for the fact that NPs spend a longer amount of time with each patient, a substitution rate of .38 seems very low. Even the concept of a substitution rate is flawed. As the report indicates on page 68 in the discussion of "Non-Physician Primary Care Providers," nurse practitioners and physicians generally work in teams, and always in collaboration. No number of NPs can totally substitute for what a physician can do because there are always tasks that are beyond the scope of an NP?s practice.

Dr. Bruce Gunn is certainly aware of the limitations of the substitution model, and the fact that additional development work is needed. In the meantime, CNAP suggests the substitution model that appears on pages 94 and 95 be deleted from the report, or at a minimum, it should be corrected and should appear with a strong caution about its reliability and applicability to policy decisions.

ACTION: Exhibit 2-2 on pp. 94-95 was deleted as suggested.

The remaining two suggestions are editorial. Page 21 refers to a definition of primary health care in 42 US Code 254b. Since most readers do not have ready access to the US Code, it would be helpful if the content of this citation were included in the report. On page 74, "(Apns)" should be written "(APNs)."

ACTION: The reference to the federal code was deleted, and APNs was corrected.

2 Table of Contents . . .